Office of EMS & Trauma System
PO Box 47853
Olympia, WA 98504-7853
360.236.2828

EMS Out of State
Certification/Challenge Training Requirements
Application Packet

Contents:

1. 530-062....Contents List/SSN Information/ Mailing Information ..... 1 page
2. 530-070....Out of State (Reciprocity)/Challenge Review and Examination Requirements. . 1 page
3. 530-063....General Instructions Checklist .....2 pages
4 530-064....EMS Out of State Application.....5 pages
5. 530-065....Confirmation Form .....2 pages
6. RCW/WAC Links and On-Line Web sites, ... 1 page

Important Social Security Number Information:

Social Security Number: You are required by state and federal law to provide a social security number with your application.If you do not have a social security number at the time you send in this application, please contact the Customer Service Center at 360.236.4700 for more formation.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

In order to process your request:

Return Completed Applications and documents to:

Office of Emergency Medical Services & Trauma System
P.O. Box 47853
Olympia, WA 98504-7853
For questions call:
360.236.2840
800.458.5281 extension 2

Introduction:

Your certification is a personal property right, and as such, may be removed through “due process” for violations of the Uniform Disciplinary Act (UDA), RCW 18.130. When you are applying for certification, it is critical that you complete the application yourself, and that you answer all questions accurately. Please do not alter the personal data questions part of the application. An altered, incomplete, or incorrectly completed application cannot be processed and will delay your possible certification.

Include this blank page when printing two-sided.
Do **not** remove.

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Out of State (Reciprocity)/Challenge Review and Examination Requirements

Refer to the reciprocity or challenge requirements memorandum on our Web site to ensure you qualify for Washington State reciprocal certification or challenge. Submit the following to the Office of Emergency Medical Services and Trauma System (OEMSTS):

A cover letter including your name, address, email and identifying what county you will be working or volunteering in Washington State.

Certification/Training Documentation:

1. **Reciprocity applicants:** provide a copy of all current state certification card(s) or national registry card. Paramedics provide proof of current or previous NREMT registration.
2. **Challenge applicants:** provide a copy of your course completion certificate or education transcripts. Paramedics – refer to the policy regarding challenges on the web site at: **http://www.doh.wa.gov/hsqa/emstrauma/challenge.htm.**

A document indicating completion of theWashington State Infectious Disease for EMS Providers, revised October 1997 or the seven-hour Department of Health (DOH) HIV/HBV program. (DOHHIV/HBV) approved training list to meet state requirements (seven hour program required for EMS personnel) can be found at: **http://www.doh.wa.gov/hsqa/emstrauma**.

A signed Washington State Specific Objective (WSSO) declaration indicating your knowledge in the WSSO for the level of certification requested. WSSO and curriculum can be found on the OEMTS Web site at: **www.doh.wa.gov/hsqa/emstrauma/publications.htm**.

Once the requested documents are received and reviewed we will notify you indicating your paperwork for reciprocity is approved or if challenging your education/training is equivalent to Washington State standards and if you will be required to take a Washington State certification examination. Contact your proctor to obtain your score approximately two weeks after your exam.

Complete this application packet and obtain necessary signatures on your application prior to submitting to OEMSTS.

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General Instruction Checklist

Check Appropriate Box: Reciprocity or challenge

Reciprocity: Applying for Washington State Department of Health certification based on current certification in another state or with the National Registry of Emergency Medical Technicians NREMT)

Challenge: Applying for certification based on other training that is determined by OEMSTS equivalent to the training requirements for a level of Department of Health certification.

☐ **#1: Demographic Information:**
Name: Please list your current first and last name with middle initial.
Social Security Number: You are required by state and federal law to provide a social security number with your application. Please call the Customer Service Center at 360.236.4700 if you do not have one.
Residential Address: Please identify the address that we should use to deliver all correspondence, including your credential. This will become your address of record for all Department of Health transactions until we are notified of a change.
Telephone Number: Enter the current number where you may be reached during normal business hours.
Email: Provide your e-mail address. This will allow us to contact you if we have any questions about your application.

☐ **#2: Personal Data Questions:**
All applicants for certification are required to answer all personal data questions. These are narrowly focused on your fitness to practice the essential skills of this profession.

If you answer “yes” to any questions in this section, you must provide an appropriate explanation and the documentation listed in the note following the question. If you do not provide the documents, your application is incomplete and will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can obtain copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- For question 5, you must answer yes if you were convicted as either a juvenile or adult. “Another jurisdiction” means any other country, state, federal territory, or military authority.

☐ **#3: Certification Level Applying for:**

- **I**ndicate the level of certification you are requesting at this time (choose only one).
- Choose either Paid or Volunteer to indicate your primary status with the EMS agency you are associated with.
- High school grad or GED required all levels except First Responder.

☐ **#4: EMS Agency Association Requirement:**
Provide all of the information regarding your Primary DOH licensed EMS agency. If you are not associated with an EMS agency licensed by the Washington State DOH, your application cannot be processed. Active association with a Washington State DOH licensed EMS agency is required for certification.

General Instruction Checklist Cont.

☐ **#5: EMS Agency Supervisor Statement:**
Your EMS agency supervisor must complete this portion of your application. **Note:** You cannot sign for yourself as supervisor. Please have your supervisor sign and date the application.

☐ **#6: Medical Program Director (MPD) Statement:**
Follow the instructions from your local EMS coordinator or EMS agency supervisor to obtain your MPD's recommendation, signature and date. Your application is not complete until it is signed and dated by the MPD recommending you for certification.

☐ **#7: Applicant's Attestation:**
You must print your name and read the statement thoroughly to ensure you understand the provisions in this section. Provide the date and the city you are in then sign the statement. This must be complete in order for us to process your application.

☐ **#8: Applicant's Photograph:**
Attach to the application a current, legible photograph showing date of birth (DOB) ie., drivers's license photo, passport, or military ID. The photograph must be clear and the information must be legible.

☐ **#9: Confirmation Form:**
Please read the form and complete the top portion, and then send to all state(s) where current EMS certifications or licenses held. (Out of state applicant's only.)

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Background Check Stamp Here

Date Stamp Here

EMS Out of State Application

Check Appropriate Box ☐ Reciprocity ☐ Challenge

Please type or print clearly. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application. Make sure you have read and understand the instructions.

1. Demographic Information

Social Security Number (- -) (If you do not have a social security number, see instructions.)

Name ☐ Male ☐ Female First Middle Last

Birth date (mm/dd/yyyy)	Place of birth		
	City	State	Country

Address

City	State	Zip	County

Country

Phone	Fax	Cell

Email address

Mailing address (if different from above)

City	State	Zip	County

Country

NOTE: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information with the department.

Have you ever been known under any other name(s)? ☐ Yes ☐ No **Circle maiden name**

If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No

If yes, list name(s):

For Office Use Only

Certification# _____ Issuance Date _____

Validation _____ Received date _____

Check Appropriate Box: ☐ Reciprocity ☐ Challenge

The Certification Level I am Applying for is: (Please Select One)

☐ First responder ☐ EMT ☐ IV Tech ☐ Airway tech
☐ IV/Airway tech ☐ ILS tech ☐ ILS W/Airway ☐ Paramedic ☐ Poison information specialist

Personal Data Questions Instructions

Personal data questions must be completed by all applicants. Return this form directly to the Department of Health to maintain confidentiality. Please follow the instructions below:

1. **Detach, review and complete pages 2 of 5 and 3 of 5 of this application. (This page and the next page). Make sure you provide accurate information.**
2. Attach appropriate additional information, and mail it to Office of EMS and Trauma System Licensing and Certification Section, PO Box 47853, Olympia, WA 98504-7853

Last Name _____ First Name _____ Middle _____

Address _____ City _____ State _____ Zip _____

Social Security Number (- -) _____ County of primary employment _____

2. Personal Data Questions

	Yes	No
1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation.	☐	☐

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.

1b. How your field of practice, the setting or manner of practice have reduced or eliminated the limitations caused by your medical condition.

Note: If you answered "yes" to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain.	☐	☐

"Currently" means within the past two years.

"Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism?	☐	☐

2. Personal Data Questions (Cont.)

Yes No

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

   "Currently" means within the past two years.

   Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

   Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile, in Washington or another state or jurisdiction? ☐ ☐

   Note: If you answered yes, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and your application will not be considered.

   To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

6. Have you ever been found in any civil, administrative or criminal proceeding to have:
   a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes? ☐ ☐

   b. Diverted controlled substances or legend drugs? ☐ ☐

   c. Violated any drug law? ☐ ☐

   d. Prescribed controlled substances for yourself? ☐ ☐

7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach explanation and provide copies of all judgments, decisions, and agreements? ☐ ☐

8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority? ☐ ☐

9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority? ☐ ☐

10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession? ☐ ☐

11. Have you previously provided the Department of Health with information regarding any "yes" answers? ☐ ☐

Applicant Statement

I certify that the above information is true and correct.

_____	_____
Printed Name	Phone Number
_____	_____
Signature	Date

3. The Certification Level I am Applying for is: (Please Select One)

☐ First responder ☐ EMT ☐ IV Tech ☐ Airway tech
☐ IV/Airway tech ☐ ILS tech ☐ ILS W/Airway ☐ Paramedic ☐ Poison information specialist

1. Will you be primarily a "paid" or "volunteer" EMS provider? ..... ☐ Paid ☐ Volunteer
2. Have you earned a high school diploma or GED certificate? ..... ☐ Yes ☐ No
(First responders exempt)

4. EMS Agency Association Requirement

Please provide the following information regarding your primary agency association:

Agency Name: _____

Address: _____

Phone Number: _____

EMS Contact Person: _____

Agency Credential Number: _____

If you are certified, will you continue to provide EMS care with this agency? ..... ☐ Yes ☐ No

5. EMS Agency Supervisor

"I affirm that if this applicant is certified, he/she will provide care with our EMS agency."

_____ _____ _____
Name of EMS Agency Supervisor (Please print) Original Signature Date

6. County Medical Program Director

The signature of the Washington State Medical Program Director (MPD) for the county where the applicant is providing care, or where his/her EMS agency is based, is required before state certification may be granted to this applicant.

☐ "I recommend certification ☐ I do not recommend certification (attach a memo for details) of this applicant based on the statements above, pending successful completion of the required examinations and/or evaluations. This applicant, if recommended for certification, has a copy of my county protocols." Protocol requirements do not apply to poison information specialists.

_____ _____ _____
County MPD's Printed Name County MPD's Original Signature Date

7. Applicant's Attestation

I, _____ , declare under penalty of perjury under the laws of the state
(print applicant name clearly)

of Washington that the following is true and correct:

- I am the person described and identified in this application.
- I have read **RCW 18.130.170** and RCW **RCW 18.130.180** of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand that I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated _____at _____ (city, state)

By: _____
Signature of Applicant

8. Applicant's Photograph

Attach to the application a current, legible photograph showing date of birth (DOB) ie., drivers's license photo, passport, or military ID. The photograph must be clear and the information must be legible.

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Do **not** remove.

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Confirmation Form

Page 1 of this form must be completed by applicant. Applicant must sign this form in the presence of a notary public.

Please make copies if necessary, and complete the top portion (please print) and send to all state(s) where current EMS certifications or licenses are held. Please note that some states may charge a fee to complete this form.

1. Authorization to Release Information to the Washington State Office of Emergency Medical Services and Trauma System

Name: _____
(Last name, First name, MI)

Also known as: _____

Mailing address: _____
(Address, City, State, Zip)

In what Washington state county will you will be working or volunteering: _____

2. Applicant's Consent

I hereby authorize the (state in which you are currently certified/licensed)_____EMS agency to furnish the information requested on Page 2 of this document.

Certification/license number: _____ EMS level/type: _____

Social Security Number: _____ Date of birth: _____
(mm/dd/yyyy)

3. Applicant's Notary

Applicant to sign in presence of notary public _____

Subscribed and sworn to before me this _____day of _____20 .

Notary public for _____ My commission expires _____
(mm/dd/yyyy)

_____
Notary signature

Notary Public Seal

4. This Section to be Completed by the State Certification or Licensure Authority

Please complete the form below, and return to EMS and Trauma System Licensing and Certification Section, PO Box 47853, Olympia, WA 98504-7853.

1. Status of EMS certification/license:

   EMS level/type of certification: _____

☐ Active certification/license no: _____Expiration Date _____/_____ / _____

☐ Inactive

2. Applicant received certification/license by: Exam ..... ☐ Yes ☐ No

Reciprocity granted on certification from _____
(State, National Registry)

3. Has this person ever been disciplined, been placed on probation or had their certification/license suspended, revoked or denied by your agency, or by the supervising physician? ..... ☐ Yes ☐ No

I hereby certify that the above is true and correct as recorded in the files of this office.

_____ _____
Signature Name (print)

_____ _____
Title Date

_____ _____
Agency State

Office of EMS & Trauma System
PO Box 47853
Olympia, WA 98504-7853
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EMS and Trauma System Reference Numbers and Links

RCW/WAC Links

Uniform Disciplinary Act,
UDA RCW 18.130..... http://apps.leg.wa.gov/RCW/default.aspx?cite=18.130

Administrative Procedure Act,
APA RCW 34.05 ..... http://apps.leg.wa.gov/RCW/default.aspx?cite=34.05

Administrative procedures and requirements,
WAC 246-12 ..... http://apps.leg.wa.gov/WAC/default.aspx?cite=246-12

Emergency Medical Services and Trauma
System WAC 246-976 ..... http://apps.leg.wa.gov/WAC/default.aspx?cite=246-976